Mumford ISD

Medication Permission Form

A parent/guardian must give a written request to administer medications at school. The medication must be in the original container and properly labeled with student's first and last name and dosage given. A separate form must be filled out for each medication.

Persons who may assist your child with medications include the school nurse (RN) and campus staff. School personnel are not responsible for any adverse effects which might occur from this medication.

NOTE: THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION MAY NOT BE GIVEN AT SCHOOL.

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN TWO WEEKS MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER.

NAME OF STUDENT: _____ DOB: _____

DRUG / FOOD ALLERGIES:_____

TEACHER: _____ GRADE: _____

PHYSICIAN NAME:_____PHYSICIAN PHONE:_____

NAME OF MEDICATION: _____

EXACT DOSAGE: _____
(Example: 400mg, 1 tsp, 2 puffs, 3 drops)

TIME TO BE GIVEN AT SCHOOL: _____
(Example: As needed, after breakfast)

REASON FOR MEDICATION: _____
(Example: ADHD, Asthma, headache)

MEDICATION TO BE GIVEN FROM: _____ TO: _____ ☐ End of School
mm-dd-yy mm-dd-yy

HOW IT IS TAKEN: _____
(Example: by mouth, inhaler, with food or after meals, empty stomach, eye drop)

ADDITIONAL INSTRUCTIONS/RESTRICTIONS: _____

HAS THIS MEDICATION BEEN ADMINISTERED AT HOME: ☐ Yes ☐ No

By signing this form, I give permission for school personnel to administer the above stated medication to the indicated student and release MISD and its employees from any claims or liability connected with its reliance on this permission.

_____ _____
PARENT'S/GUARDIAN SIGNATURE DAYTIME PHONE

_____ _____
PARENT'S/GUARDIAN NAME (printed) DATE

RN Signature of Review: _____ Date of Review:_____